Office of Accessibility
1247 East Siena Heights Drive
Adrian, MI 49221

Telephone# 517-264-7651
Fax# 833-413-2849

AIR CONDITIONER REQUEST DUE TO A DISABILITY

Name		
Date of Birth	SID #	Cell Phone Number

This Air Conditioner Request Form is to be thoroughly completed and returned to the Office of Accessibility. Incomplete forms will not be reviewed.

This Form is to Be Completed by a Licensed Physician or Medical Specialist:

Please respond to the following questions regarding the student named above:

1.) Please indicate when you first started seeing the above-named patient for the impairment/condition described in this form:

_____
_____
_____

2.) As per the American with Disabilities Act, please indicate whether the student has a physical or mental impairment that substantially limits a major life activity, and if so, what the condition is, what major life activity is substantially limited by it, and how the major life activity is substantially limited by the impairment:

_____
_____
_____

5.) What is the severity of the condition?

_____
_____
_____

6.) How long is this condition likely to persist?

_____
_____
_____

7.) Describe the symptoms related to the student's condition, if any, that cause significant impairment in one or more major life activities and which would support the student's request for the accommodation being requested:

_____
_____
_____

8.) Please identify any prescription and/or over the counter medications taken to manage symptoms with frequency of the dose.

_____
_____
_____

9.) Are allergy injections given? Yes ◯, or No ◯

- If Yes: what type and frequency:

  _____
  _____

10.) Are the symptoms: Continuous ◯, Intermittent ◯ or Seasonal ◯?

11.) Are the symptoms: Mild ◯, Moderate ◯, or Significant ◯?

12.) Is the use of an air conditioner: Desirable ◯ or Essential ◯ to participate in the College's residential program?

13.) In your opinion, how important is it for the student's well being to have the accommodation being requested? (1 = not important, 5 = critically important). 5 Critically Im

The provider may also send a report that provides additional related information. *The provider completing this form cannot be related to the student and must practice in the specialty area related to the condition identified.*

Signature of Provider:_____Date: _____

Address: _____

City:_____State:_____ ***Affix Office Stamp Below***

Telephone #: _____

Fax #: _____

OFFICE USE ONLY

Request Reviewed: Date _____ Approved_____Denied: _____

By_____

Student Notified: Date_____ By: E-Mail_____Letter_____

Residence Life Notified: Date _____ By: E-Mail_____Letter_____